# XV THE PSYCHIATRIC SYSTEM

## THE INTERPERSONAL THEORY OF HARRY STACK SULLIVAN

The first and foremost psychoanalytic theorist in the United States was Harry Stack Sullivan, who defined psychiatry as the study of interpersonal relations. The theory was a result of his striving for "a rational system as to what can be done about anyone anywhere who is not living as well as he seems capable of living with his fellow man." Sullivan believed that "man is more simply man than different one from another," and therefore he stripped his psychiatric system of any particular cultural heritage in the pursuit of a universal theory.

Born in Norwich, New York, in 1882, Sullivan attended Cornell University briefly and then Chicago College of Medicine and Surgery, from which he graduated in 1917. His professional career can be roughly divided into four periods. During the Chicago period (1917 to 1921), he was first an industrial surgeon at a steel mill, where an interest in psychiatry developed, and then became a lieutenant in the U.S. Medical Corps during World War I. He remained assistant medical officer until 1922, when he was appointed liaison officer of the Veterans Bureau to St. Elizabeth's Hospital in Washington, D.C. During the Washington–Baltimore period (1922 to 1931), he worked at St. Elizabeth's Hospital under William A. White, the superintendent, and then for 7 years at Sheppard and Enoch Pratt Hospital in Towson, Maryland. There Sullivan conducted pioneering research on schizophrenia and laid the foundation of his interpersonal theory. He lived in the hospital and allowed his patients to call on him anytime. David McK. Rioch had the following recollections:

*It has seemed to me that though his theoretical contributions have advanced psychiatry as a social-biological discipline, Sullivan's main clinical effectiveness stemmed from championing the schizophrenic group of patients and attacking—tooth-and-nail, as it were—anyone who derogated, molested, or neglected such patients. That is, he was on the patients' side, first and last. In the hospital they were "My schizophrenics!" Nobody should interfere with them! Needless to say, the convulsive, anoxic, and psychosurgical methods were anathema to him. (1985)*

During his New York period (1930 to 1939), Sullivan engaged in a private practice and abandoned the study of schizophrenia, choosing to see only patients with the obsessive-compulsive syndrome.

With the outbreak of World War II began the last period of Sullivan's career (1939 to 1949), during which he engaged in private practice in Washington, D.C., and associated with the Washington School of Psychiatry. The William Alanson White Psychiatric Foundation, which Sullivan helped establish in 1938, supported (1) Washington School of Psychiatry, at which Sullivan taught; (2) *Psychiatry: Journal of the Biology and the Pathology of Interpersonal Relations,* co-edited by Sullivan; and (3) William Alanson White Memorial Lectures, the first of which Sullivan delivered in 1939.

Sullivan also helped establish criteria for the Selective Service System at the outbreak of World War II, and made significant contributions toward international peace after the war and until his death in 1949. During his life, Sullivan authored numerous scientific articles and a book entitled *Conceptions of Modern Psychiatry* (1940). A large part of his writings, however, are contained in six books published posthumously: *The Interpersonal Theory of Psychiatry* (1953), *The Psychiatric Interview* (1954), *Clinical Studies in Psychiatry* (1956), *Schizophrenia as a Human Process* (1962), *The Fusion of Psychiatry and Social Service* (1972), and *Personal Psychopathology* (1972).

A precept of the interpersonal theory is that humans require interpersonal relations, that they have needs for satisfaction (food, shelter, sleep, the physical presence of another, lust) and for security (self-esteem or self-respect). Sullivan believed that man is vulnerable to anxiety, which "arises from one's relations with others in the later stages of life and manifests itself fairly readily under provocation as a rationalization pertaining to the ill-esteem of another." The relation of infant and mother, upon which so much depends in later life, is the beginning phase of development, from birth to "almost invariably 15 or more years." Sullivan believed that "unfortunate experiences at any developmental phase may do great damage to one's possibilities of future interpersonal relations."

In an introductory lecture to students at Washington School of Psychiatry a year before his death, Sullivan presented the goal of the psychoanalyst:

*Some of you who like myself have an agricultural background realize that much of the heartache of the farm is the weeds; but the weeds are not that which is essential on the farm. The crop is essential, but the weeds are the trouble. And so it is in psychotherapy: Anxiety is the problem, but the unnumbered operations which human skill has devised— your patients' skill and experience have devised—to avoid and minimize anxiety, are what you have to struggle with in getting to the problem. But very much like the farmer's experience—after he has killed some weeds, other weeds will appear—in this work concentration on the unnumbered security operation, the protective performances, and so on, called out by hints of anxiety can go on forever. You can make a good living doing that. The only thing you can't do is make very marked change in the patient, aside from the process of aging. . . . When you have become fairly clear on the specific*

*and particular vulnerabilities to anxiety which are irrational from the standpoint of the broader culture or the particular world in which a person is living or is to live, you have come to that which can be cured, that to which psychotherapeutic technique can apply (1949).*

—CHARLES STEWART ROBERTS

**REFERENCES**

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Sullivan HS. The study of psychiatry. 1948 Orienting lectures. Psychiatry: Journal for the Operational Statement of Interpersonal Relations 1949;12:325–37.

# 199 | An Overview of the Psychiatric System

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The discussion of the psychiatric system in the following chapters focuses on areas of the psychiatric evaluation that are of particular importance. Inquiry into previous psychiatric problems (Chapter 200) allows the physician to understand the extent to which the patient has been vulnerable to emotional and/or mental problems in the past and may be of prognostic value in determining how the patient may respond to present problems. The effect of the patient's present symptoms upon his interpersonal relationships (Chapter 201) gives important information about the severity of the problem. As this area is explored the physician will acquire important information about support systems that are available to the patient. Anxiety, depression, and disturbances of vegetative function (Chapters 202, 203, and 205) are important components of any exploration of the patient's presenting problem.

Alcoholism is usually ranked as the third most severe public health problem in the United States, exceeded only by cardiovascular disease and cancer. Questioning the patient about substance abuse (Chapter 206) is very important. If not specifically asked for information in this area, many patients will omit it. It is useful to check the information given about use of drugs and alcohol with a member of the patient's family because many alcoholics and drug users practice extensive denial. Episodes of loss of control (Chapter 204) should be explored in relationship to both the present problem and previous psychiatric problems. The mental status examination (Chapter 207) gives vital information about current mental and emotional functioning. Chapter 208 on frequently performed psychologic tests describes procedures that can be used to provide important supplemental information in regard to specific areas of mental and emotional functioning.

## General Principles

In approaching the psychiatric patient it is important to distinguish between the psychiatric history and the psychiatric report. The psychiatric report summarizes the findings in a convenient form for information retrieval. Table 199.1 gives an example of a psychiatric evaluation report format. It is important to remember that with psychiatric patients one may not acquire the information in the same order that it is written in the psychiatric report.

From your first contact with a psychiatric patient, it is important to give much attention to establishing rapport. A patient who is having a laceration sutured may have only slight rapport with the physician without major interference with the surgical procedure. Such is not the case in psychiatry. It is very difficult for patients to unburden themselves regarding intimate emotional aspects of their life unless they feel comfortable with the person doing the psychiatric examination. With this in mind, it is important that you give careful attention to the external surroundings in which the examination is taking place. In particular, you should be sure that the patient has reasonable privacy. Drawing a curtain in a hospital room will suffice for doing a physical examination but will be very inadequate as far as providing an appropriate situation for a psychiatric examination. When you are obtaining a psychiatric history in a hospital setting, make arrangements for a private room in which to do this. In general, nurses and other hospital personnel understand that privacy is needed and will be cooperative in helping you make these arrangements. Attention should be given to the patient's comfort. The room in which the interview is conducted should be quiet and have comfortable seating arrangements. Many psychiatrists prefer to conduct their interviews face to face, sitting in a chair opposite the patient, rather than across a desk. Other psychiatrists feel that talking to a patient across a desk is not detrimental to the interview.

It is useful to have several places available for the patient to sit so that the patient can choose the most comfortable position. Taking a complete psychiatric history often involves several hours. Be very careful not to exhaust the patient. Breaks should be taken at intervals of not longer than 1 hour.

When the interview begins, be certain that the patient fully understands the situation. In the psychiatric interview it is particularly important to be straightforward with the patient. The patient should know who you are and what your status is. The patient also has a right to know what will be done with the information given to you. The patient has a right to confidentiality, and if the patient indicates that he or she wishes to tell you something off the record, this wish can be respected, provided that the patient understands that confidentiality cannot be maintained if there is imminent danger to self (suicide) or others (homicide). You should also let the patient know what procedures are used to ensure confidentiality of the psychiatric record so that the patient will feel comfortable in allowing information to be entered on the chart.

At the beginning of the interview it is often useful to obtain some basic demographic information about the patient including name, address, telephone number, date of birth, marital status, occupation, and living circumstances. Asking for this information frequently provides a nonthreatening introduction to the psychiatric history and at the same time gives the examiner a clear picture of the life circumstances of the patient. After this information is obtained, the patient can be asked for the chief complaint and the history of the current emotional illness.

Much of the information obtained in psychiatric interviews comes as a result of the use of open-ended questions. During the psychiatric history the examiner will often intersperse open-ended questions with close-ended questions, thereby maintaining a flexible approach. At times patients will be under such pressure to discuss their current problems that they plunge into them before giving the identi-

**Table 199.1**
Psychiatric Evaluation Report

**Referral information**
Reason for referral
Person making the referral
Circumstances of the referral

**Identifying information**
Informant(s): Person or persons from whom the history was
 obtained
Name
Address
Telephone
Birthdate, age
Race
Sex
Sibling rank
Marital status
Resides with
Nationality
Language if other than English
Religion

**Personal appearance**
Physical description of patient
Attitudes and mannerisms during the interview
Estimation of reliability of the history as obtained from the
 informant(s)

**Chief complaint**
Brief description in a few sentences of the patient's primary
 reason for coming to treatment

**History of the present problem**
Description of problems as expressed by the patient
Date of onset and course of symptoms
Precipitating factors
Effect of symptoms on current function in personal relationships
 and life activities:
 Family
 Occupation
 Social
 Sexual behavior
Results of any treatment given before this evaluation

**Previous illnesses**
Psychiatric: Date, type, and results of treatment
 Emotional or mental disturbances
 Psychosomatic
Medical conditions: date, type, and results of treatment
Neurologic disorders: date, type, and results of treatment
List of all hospitalizations

**Personal history**
*Family history:* Brief statement about father, mother, siblings, and
 their relationships with each other and with the patient
*Developmental history:* Birth history, physical and mental
 development during childhood and adolescence, parental care
 and discipline, socialization, activities
*Educational background:* Include age school was begun and
 terminated, grade level attained, special training,
 achievements, reaction to teachers and authority, school
 activities and participation

**Employment**
Age began work
Type of work
Chronologic listing of jobs held and reasons for terminating
Current employment
Future plans and ambitions

**Marital/sexual history**
Age began dating
Frequency of dating
Number of marriages and reasons for termination
Reasons for divorce, separation
Sexual experiences and adjustment; any problems in sexual
 performance
Children: Names, ages, place of residence, and if adult,
 occupation and amount of contact with the patient

**Substance use history**
Use of alcohol
 Amount and frequency
 Any alcohol-related problems such as traffic violations,
  absenteeism from work, or injuries while intoxicated
 Advice from others to reduce the amount of drinking
 Binges
 Blackouts (i.e., inability to remember events during a period of
  drinking while appearing to behave in a fairly normal
  fashion)
 Efforts to reduce alcohol consumption in the past
 Presence of tolerance
 Any history of withdrawal symptoms
Use of drugs
 Drugs used; amount and frequency of use
 Effect of the drugs used
 Problems associated with drug use

**Areas of strength**
Educational achievement
Marriage
Vocational achievement
Special talents
Family support
Organized groups (lodges, church, etc.)

**Mental status examination**

**Present medical history**
Chief complaint, if any
Present illness, if any
Review of systems (include pertinent positives and negatives)

**Physical examination**

**Pertinent lab or x-ray results**

**Diagnostic impression**
Multiaxial diagnosis[a]
 *Axis I:* Clinical syndromes
 *Axis II:* Personality disorders, specific developmental disorders
 *Axis III:* Physical disorders and conditions
 *Axis IV:* Severity of psychosocial stressors
 *Axis V:* Adaptive functioning
Statement of psychodynamic issues
Prognosis

**Plan for treatment**

**Economic situation**
Income
Obligations, debts

**Motivation toward treatment**


NAME OF INTERVIEWING DOCTOR _____
DATED _____

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[a]Based on the nomenclature of the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition).

fying information. It is appropriate for the examiner to follow the patient's thinking in this regard and to go back for the basic identifying information later rather than interfere with the patient's train of thought. Thus, while the information received will be recorded in the psychiatric report in a standard fashion, the sequence in which this information is obtained in the actual interview may vary considerably from patient to patient.

Nonverbal communication is particularly important during the psychiatric evaluation. Facial expressions, tics, gestures, tonal inflections, and posture may be of great help to the examiner in assessing the patient's feelings. For example, a patient who tightens her lips and frowns slightly each time she mentions her husband may be giving a definite though unconscious indication of marital discord regardless of what she says verbally.

The physician should make a strong effort to be open and clear in communicating with the patient. If he or she is going too fast for you, say so. At times, the examiner should rephrase and summarize what the patient has said to be certain that the information given has been accurately received. The patient should be encouraged to talk, but the examiner needs to avoid asking leading questions. Nodding occasionally may be an encouragement for the patient to continue talking, but constant nodding by the examiner is often distracting to the patient.

## Psychiatric Evaluation

Unless a physical examination is done as a part of the psychiatric evaluation, no special tools are needed. Obviously, the examiner should be certain that he or she has an adequate supply of pens, pencils, and papers. A watch or clock should be available for monitoring the elapsed time for each part of the evaluation.

The usual sequence of evaluation procedure begins with an introduction of the examiner to the patient (Table 199.2). After making certain that the patient is reasonably comfortable, the examiner obtains the demographic information listed on the Psychiatric Evaluation form (Table 199.1) under "Identifying Information." The the examiner inquires regarding the circumstances leading to the referral. At this point a smooth transition can usually be made into a discussion of the "Chief Complaint" and "History of the Present Problem." By this time, most physicians have already made many of the observations listed under "Personal

**Table 199.2**
Typical Sequence for Psychiatric Evaluation

Introduction of self by physician to patient
Identifying information
Referral information
Chief complaint
Present problem
Previous illnesses
Present medical history
Personal history
Employment
Marital/sexual history
Substance use history
Financial status
Areas of strength
Mental status examination
Feedback to patient

Appearance." Next the physician inquires about "Previous Illnesses" both medical and psychiatric. Then the physician can inquire regarding the patient's current physical health, making sure to list any medications being taken at the time of the evaluation and any medications to which the patient has an allergy.

The examiner next moves to record the patient's personal (i.e., family, developmental, and educational), occupational, marital, and drug/alcohol history. Inquiry is usually made into the patient's sexual history as a part of the marital history. The examiner should make detailed inquiry into sexual habits, preferences, and problems as long as the patient is reasonably comfortable with this. If the patient indicates major discomfort in this questioning, however, the examiner should make note of this fact and move to other areas. During later interviews, after more rapport has developed, full discussion of this topic can be carried out.

The patient's financial status is then explored to the extent pertinent to his psychiatric problem. Next, areas of strength such as special training or talents should be listed.

At this point in the interview the mental status examination is usually done. Some explanatory remarks regarding the Mental Status Examination should be made. Patients can be told that they will be asked some questions of a different type designed to help find out how much their psychiatric problem is affecting their mental and emotional functioning. They should be encouraged to attempt to answer all the questions even when they are difficult.

## Diagnosis and Prognosis

At the end of the evaluation the examiner should be prepared to give feedback to the patient. This is usually accomplished by asking the patient if he or she has any questions. Patients often ask what their diagnosis is. Many psychiatrists see no problem in telling patients the diagnosis, while others feel that it is best to answer patients in general terms rather than actually naming the diagnosis, particularly if the diagnosis is a major psychosis such as schizophrenia. Whenever the diagnosis is told to a patient, the physician should always do this at a point when he or she has ample time to discuss fully with the patient the implications of the diagnosis.

Frequently, laboratory studies and psychologic testing are ordered. When this is the case, the examiner should explain why these tests are being ordered.

Finally, patients often want to know their prognosis; that is, what their chances for recovery are. In most psychiatric patients there is a strong likelihood of recovery or at least of significant improvement. Consequently, the physician can as a rule be both honest and optimistic. If the prognosis is not a favorable one, however, the situation will eventually need to be communicated to the patient, but not usually during the initial interview. After the physician has seen the patient frequently enough to build strong rapport (often 5 to 10 visits), even an unfavorable diagnosis can usually be discussed at length with the patient.

When the psychiatric evaluation has been completed, the physician should have collected data that will allow him or her to establish a working diagnosis and develop an initial plan of treatment. If the evaluation is conducted in a warm and empathic way, the physician will also have established rapport with the patient that will form the basis for an effective therapeutic relationship.